Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: ROSE SURGICAL CENTER 4700 EAST HALE PARKWAY SUITE 200 DENVER CO 80220	MFDR Tracking #: M4-09-9155-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO Box #: 54	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim was underpaid by **$596.06**."

Amount in Dispute: $596.06

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor did not indicate with its initial billing a request for separate reimbursement of the implants. (Exhibit 1)." "Exhibit 1 clearly reflects no such certification." "For these above reasons Texas Mutual believes no further payment is due."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Denial Code(s)	Amount in Dispute	Amount Due
11/12/2008	Ambulatory Surgical Care Services for CPT code 26735	CAC-45, 793, CAC-W4, 891, CAC-18, 878	$596.06	$161.46
	Ambulatory Surgical Care Services for CPT code 99070	CAC-5, 393, CAC-W4, 891, CAC-18, 878		$0.00
			Total Due:	$161.46

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Division rule at 28 TAC §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 2/17/2009

   - Reimbursement made in accordance with Rule 134.402(F)(1). Separate reimbursement for implantables was not requested in accordance with Rule 134.402(G).
   - CAC-45-Charges exceed your contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
   - CAC-5-The procedure code/bill type is inconsistent with the place of service.
   - 393-This procedure code is not in the ASC fee schedule or does not have the modifier SG identifying it as an ASC code.
   - 793-Reduction due to PPO contract

Explanation of benefits dated 3/19/2009

- Reduction due to PPO contract.
- CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
- CAC-45-Charges exceed your contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
- CAC-5-The procedure code/bill type is inconsistent with the place of service.
- 393-This procedure code is not in the ASC fee schedule or does not have the modifier SG identifying it as an ASC code.
- 793-Reduction due to PPO contract
- 891-The insurance company is reducing or denying payment after reconsideration.

Explanation of benefits dated 4/23/2009

- Reduction due to PPO contract.
- CAC-18-Duplicate claim/service.
- CAC-45-Charges exceed your contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
- CAC-5-The procedure code/bill type is inconsistent with the place of service.
- 393-This procedure code is not in the ASC fee schedule or does not have the modifier SG identifying it as an ASC code.
- 793-Reduction due to PPO contract.
- 878-Duplicate appeal. Request medical dispute resolution through DWC for continued disagreement of original appeal decision.

Issues

1. Does the submitted documentation support the respondent's position that a PPO contract exists between the parties?
2. Does the submitted documentation support the respondent's EOB denial reason code "CAC-18-Duplicate claim/service" and "878-Duplicate appeal. Request medical dispute resolution through DWC for continued disagreement of original appeal decision"?
3. Is CPT code 99070 reimbursable in ASC fee guideline?
4. Does the submitted documentation support the respondent's position that separate reimbursement was not requested for implantables?
5. Is the requestor entitled to additional reimbursement?

Findings

1. According to the explanation of benefits, the services in dispute were paid using a contracted fee arrangement. Texas Labor Code §413.011(d-3) states that the Division may request copies of each contract under which fees are being paid, and goes on to state that the insurance carrier may be required to pay fees in accordance with the Division's fee guidelines if the contract is not provided in a timely manner to the division. On October 21, 2010, the Division requested a copy of the contract between the network and the health care provider from the insurance carrier. The insurance carrier failed to provide a copy of the requested documentation. For that reason, the disputes health care will be reviewed in accordance with applicable Division rules and fee guidelines.
2. The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported.
3. The requestor billed CPT code "99070-Special supplies" for the implantables. According to ADDENDUM B, CPT code 99070 is a status "B" code. Per Medicare, status B codes are for bundled services and are not paid separately. The Division finds that reimbursement for CPT code 99070 is not supported in ASC fee guideline.
4. The respondent states in the position summary that "The requestor did not indicate with its initial billing a request for separate reimbursement of the implants." "For these above reasons Texas Mutual believes no further payment is due."

   Division rule at 28 TAC §134.402(f)(1)(B) states "if an ASC facility or surgical implant provider requests separate reimbursement for an implantable…"

   Division rule at 28 TAC §134.402(g) states "A facility, or surgical implant provider with written agreement of the facility, may request separate reimbursement for an implantable."

   A review of the submitted medical bill and documentation does not support that the requestor requested separate

reimbursement for the implantables in accordance with Division rule at 28 TAC §134.402(f)(1)(B) and (g). Therefore, the reimbursement is applicable to fee schedule outlined in Division rule at 28 TAC §134.402(f)(1)(A).

5. Division rule at 28 TAC §134.402(f)(1)(A) reimbursement for non-device intensive procedure for CPT code 26735-LT is:

   The national reimbursement is found in the ADDENDUM AA ASC Covered Surgical Procedures for CY 2008 = $1,083.02.
   The national reimbursement is divided by 2 = $541.51 ($1,083.02/2).

   This number X City Conversion Factor/CMS Wage Index for Dallas, TX is $541.51 X 0.9915 = $536.91.

   The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted half of the national reimbursement $541.51 + $536.91 = $1,078.42.

   Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $1,078.42 X 235% = $2,534.28.

   The MAR for CPT code 26735-LT is $2,534.28. The insurance carrier paid $2372.82. The difference between amount due and paid equals $161.46, this amount is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that per Division rule at 28 TAC §134.402(f)(1)(A), additional reimbursement of $161.46 is due the requestor. For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $161.46.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $161.46 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	4/5/2011 Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.